RESPECTING OURSELVES AND OUR PATIENTS: 
IMPROVING PATIENT SAFETY BY IMPROVED HANDLING OF VIOLENT PATIENTS

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Workplace violence in the healthcare setting is increasing in prevalence in nearly all locales. In this session, we will work together to better understand the prevalence, scope, and down-stream effects of the problem, along with programmatic elements that begin to address violent patient handling.

Workplace violence has several definitions, nearly all of which are more inclusive than merely counting physical harms visited upon the healthcare worker. Some of the definitions of workplace harm include:

• **World Healthcare Organization (WHO):** “The intentional use of power, threatened or actual, against another person or against a group, in work-related circumstances, that either results in or has a high degree of likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation”

• **National Institute for Occupational Safety and Health (NIOSH):** “Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide.” (Note: Threats may be conveyed via verbal, physical or electronic means, or physical assault)

It may be useful to consider these different types of violence:

• Assault/attack: Intentional behavior that harms another person physically, including sexual assault
• Abuse: Behavior that humiliates, degrades or otherwise indicates a lack of respect for the dignity and worth of an individual
• Harassment: Any conduct based on individual characteristics or other status that is unreciprocated or unwanted and which affects the dignity of men and women at work
• Threat: Promised use of physical force or power (i.e. psychological force) resulting in fear of physical, sexual, psychological harm or other negative consequences to the targeted individual

Given such definitions, the following figure depicts the proportion of healthcare workers who, according to surveys, have experienced violence at work.
It is also useful to consider the source of the violence, and by convention, the source has been categorized in the following way:

- **Type I**: Criminal intent by perpetrator with no legitimate relationship to worksite (e.g., robbery)
- **Type II**: Perpetrator is a customer receiving services from the company (e.g., patient or visitor at a hospital)
- **Type III**: Perpetrator is employed by the establishment (e.g., worker assaults co-worker)

The majority of violence against healthcare workers is of Type II, hence the topic of this talk. At Mayo Clinic, we had initially embarked on a Violent Patient Handling Project. This project is nearing completion and will transition into a sustainable program with ongoing learning and improvement. We will discuss aspects of governance and ownership as important characteristics of an effective program.

The underlying causes of Type II violence extend well beyond the condition of the patient, and encompass societal and organizational factors. In designing programs to violent patient handling, it is important to consider these factors (Figure). On the left are the several “systems” influencing the likelihood of violent behavior in the healthcare setting. In the middle is an approximation of how much those systems may be under your organizational influence, along with an estimated timeline to anchor expectations for program development, though faster would be better. On the right are examples of activities that might influence the systemic causes of Type II violence.
The program we have been working on thus far includes significant activities in the following areas:

- Safety Coordination
- Accurate and concurrent reporting
- Facility and Culture Accountability
- Education for all staff
- Linked activities

Useful references are listed below.


